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ABSTRACT

This paper provides a description and analysis of the development, implementation, and continuing framework of practice for a model of comprehensive, coordinated maternal and child health programs in which traditional maternal and child health services are provided by a local county health department while family planning and related services are provided by a private non-profit agency. Clients' benefits of increased accessibility, continuity, and coordinated care are examined. It is noted that prenatal, child health, sexually transmitted disease, and nutrition services are integrated through formal and informal arrangements with the family planning provider. The paper discusses interstaff interaction, communication patterns, problem-resolution techniques, formal and informal linkage agreements, and cost efficiency. Included in the presentation are reactions from patients, staff, administration, and outside agencies routinely involved with both programs. The cumulative result of the model is a larger pool of cooperating health and allied professionals providing care and serving as resources for client and family. The cost efficient approach is shown to be a model for the community at large, demonstrating a potential for less fragmentation of the health care system to the consumer. The overall impact is the framework for larger community networking and the implementation of an effective client/family advocate system.
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INTEGRATING A FAMILY PLANNING PROGRAM
 WITH A COUNTY HEALTH DEPARTMENT BASED
 MATERNAL AND CHILD HEALTH PROGRAM

This paper provides a description and analysis of the development, implementation and continuing framework of practice for a model of comprehensive, coordinated maternal and child health programs. Traditional maternal and child health services are provided by a local county health department while family planning and related services are provided by a private non-profit agency. Clients' benefits of increased accessibility, continuity and coordinated care are examined. Prenatal, child health, sexually transmitted disease, nutrition services are integrated through formal and informal arrangements with the family planning provider. The paper discusses interstaff interaction, communication patterns, problem-resolution techniques and formal and informal linkage agreements. Patient identification of service providers with reaction to coordinated services is outlined. Cost efficiency is discussed. Involved in the presentation are reactions from patients, staff, administration and outside agencies routinely involved with both programs. The cumulative result of the model is a larger pool of cooperating health and allied professionals providing care and serving as resources for client and family. The cost efficient approach proves to be a model for the community at large, demonstrating a potential for less fragmentation of the health care system to the consumer. The overall impact is the framework for larger community networking and the implementation of an effective client/family advocate system.

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INTEGRATING A FAMILY PLANNING PROGRAM
WITH A COUNTY HEALTH DEPARTMENT BASED
MATERNAL AND CHILD HEALTH PROGRAM

GOAL: An EFFECTIVE, COORDINATED and INTEGRATED system
of health care for families

PURPOSES: Increasing service AVAILABILITY

Increasing EASE OF ENTRY into health care systems

Increasing client SATISFACTION

DECREASING fragmentation of care

REDUCING program costs

LENGTHENING the interconceptual span

Our national goal is to continue to improve infant health. Infant mortality has been declining in New Jersey as well as in the United States, however it is still unacceptably high, especially among non-white infants. Many of the factors which are known to be associated with infant mortality are reflections of poverty and its social effects. However, the first factor that should be considered in an effort to reduce infant mortality is reduction of unwanted, unplanned, or medically contraindicated pregnancies. Outreach programs that enhance practical accessibility and timely use of the services are necessary. This project describes a successful approach to provide comprehensive and coordinated care to women who may be considered to be at high risk for increased rates of potential infant morbidity and mortality. Our goal is to produce an effective system of health care by providing increasing service availability, increasing access of entry into health care systems, increasing client satisfaction, lengthening the interconception span, decreasing fragmentation, and decreasing costs.

Family Planning Services were developed outside the County Health

Department system in the early 1970's. Community leaders incorporated to develop a private non-profit reproductive health care service through the use of public health and social service contracts; our agency currently provides services to 5,000 unduplicated medical users, 2,500 seen in the County under discussion today.

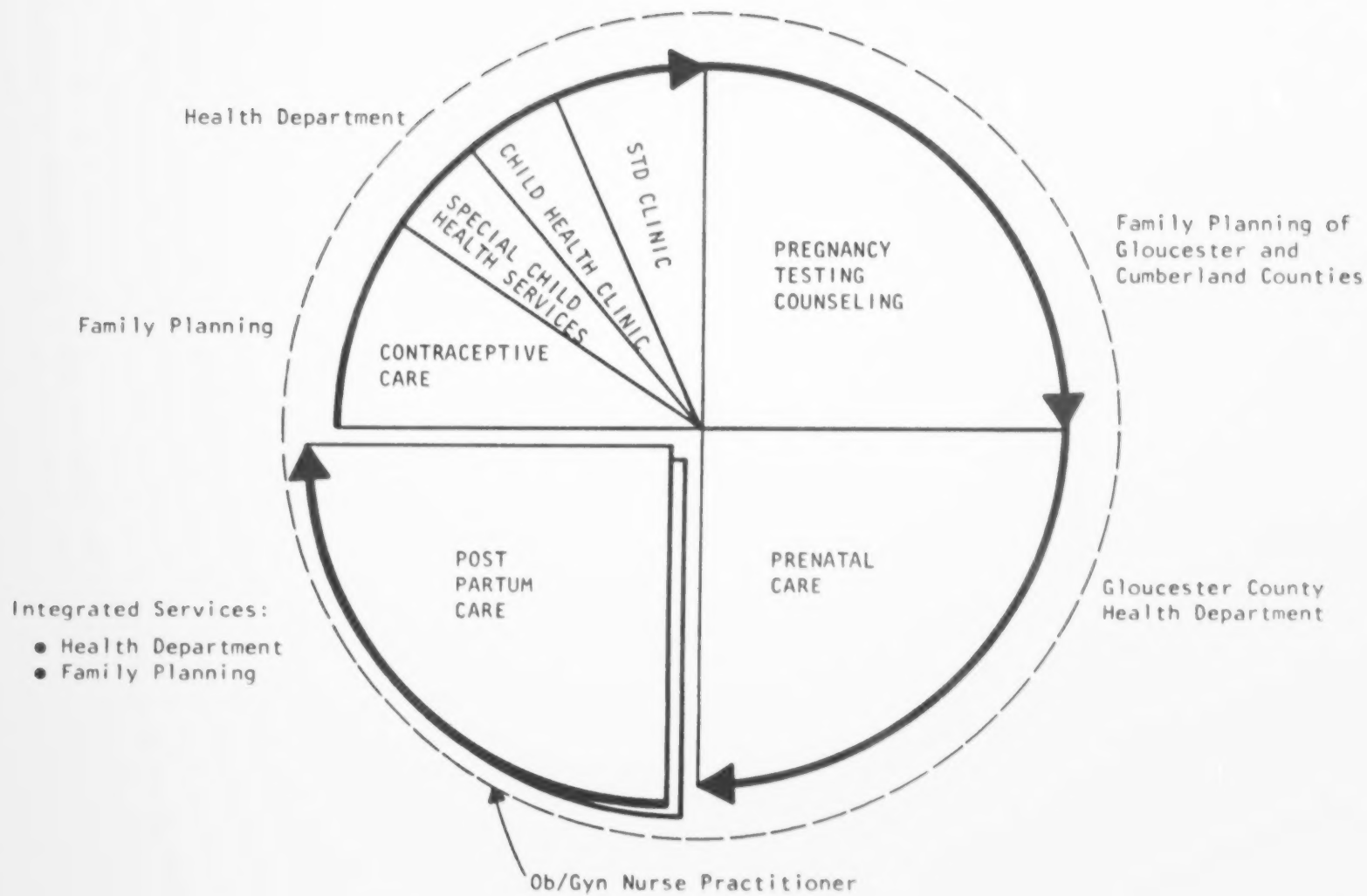
The County Health Department is responsible for all State mandated and elective services including obstetrical, child health, community screening programs and case management services for children with handicapping conditions as well as other public health care concerns such as communicable disease control. Nutritional services are provided in close coordination with the W.I.C. program.

Since inception of the Family Planning Service, there has been a conscious effort on behalf of both agencies to provide coordinated service delivery. The goal has been to provide services where possible in a singular facility. The model intended to demonstrate that through the rotation of days in a single site, and at times co-sharing during hours of operation, community identity of a health facility for each population center. In 1976, when Family Planning Services expanded their service delivery, the concept of coordinated care was

implemented. The Gloucester County Health Department adjusted their clinic schedule by offering the facility two days a week. The space, including exam, laboratory, counseling, waiting and record rooms, and laboratory space were offered at no charge. This was later assessed as a kind match for the family planning grants. To assist in development of the program, the Health Department offered file cabinets and use of equipment including scales, exam tables, and other furniture. The projected cost savings was thousands of dollars, alleviating the need for the family planning agency to purchase equipment. Later, a third site was opened jointly by the Health Department and Family Planning based on population shifts and needs identified by both agencies. Costs were shared in the purchase of equipment, example: each program assumed responsibility for the set-up for one exam room. In 1979 upon the completion of the remodeling of the Family Planning Office, the County Health Department moved its programs into the Family Planning Office, completing the concept model. Ultimate coordination was exemplified in 1983 when the Health Department moved a satellite nursing service into a vacant office located next to the Family Planning Agency. As a result of the

relocation, the patient was able to be registered into either service, alleviating fragmentation of services often resulting in clients "falling through the cracks". Patients discovered the ease of locating services without having to make additional telephone contacts or waiting for staff to return at designated times to receive services. However, because of the growth of the Health Department services, space constraints resulted in relocation, and return to the former model of a shared facility. The model of coordinated care is clarified by several specific examples.

Subsequent to pregnancy testing and counseling conducted by Family Planning, eligible patients indicating preference for prenatal care are referred directly to Health Department. In the prenatal clinic, patients enter the coordinated effort through both agencies use of the same nurse practitioner. Through contractual arrangements, the Health Department utilizes the skills of Family Planning's staff OB-GYN nurse practitioner. Under the care of the nurse practitioner during her pregnancy, the patient later may find her nurse practitioner offering contraceptive services through the Family Planning Program.

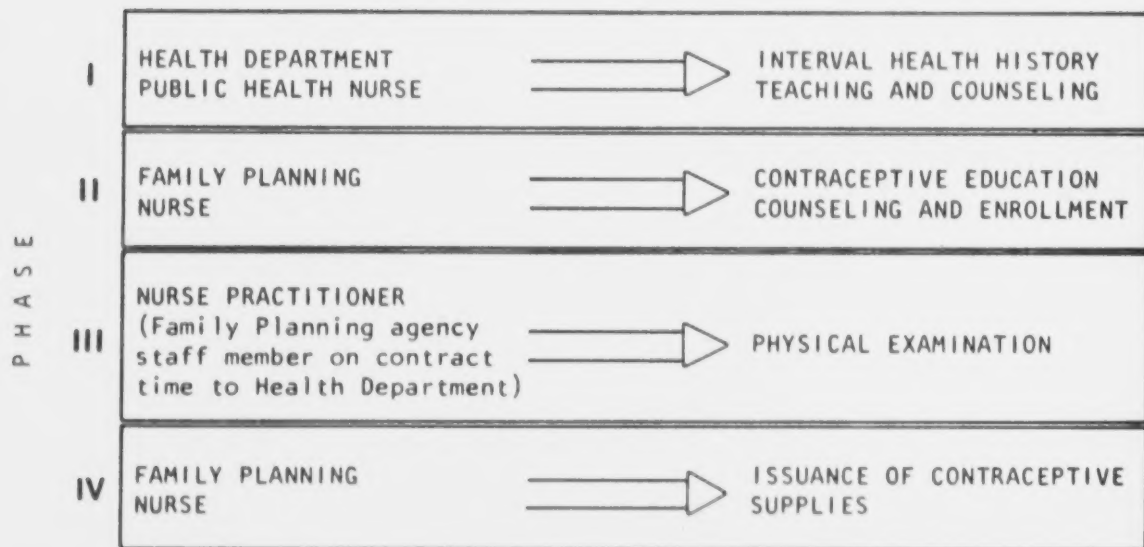


P A T I E N T E D U C A T I O N S E S S I O N S

<u>TOPIC</u>	<u>FACILITATOR</u>
Normal discomforts of pregnancy	Public Health Nurse, Health Dept
Prenatal nutrition	Nutritionist, Health Dept
Relaxation	Social Worker, Health Dept
Infant care	Pediatric Nurse Practitioner, Health Dept
Family planning	Health Educator, Family Planning

Other examples of the integrated prenatal service delivery system are the education, nursing and pharmacy services available at the prenatal clinic. The Health Department offers an ongoing patient group education session as part of each scheduled visit. The presence of the family planning educator in the group sessions provides the patient and her family an additional resource prior to delivery. Patients are exposed to the continuity of concern for their total well being, pre and post delivery. As can be seen on Slide 5, initial family planning services are provided on site by a Family Planning nurse at the post partum visit. With this service, Health Department nursing staff need not assume responsibility for the patient counseling as recommended by state licensing and program authorities. The Family Planning Agency benefits from the ease of patient enrollment, while the patient is spared having to have repeat laboratory work and physical examination. Additionally, a staff-patient relationship is established at a vulnerable phase of the recovery period. The experience of a friendly and inviting family planning nurse integrated into the system where the client has already established a previous rapport, brings validity to the new counseling relationship. It is theorized that the patient will

POST PARTUM VISIT



be a more effective contraceptive. Because the relationship facilitates service utilization in and through knowledge of a specific staff member, a diluted case manager concept is established. In this model, contraception may be initiated when the patient displays the greatest amount of interest. Without the system patients can easily be lost to follow up. Moreover, the traditional model often fails to allow sufficient time to discuss patient post partum concerns.

Key elements in the coordination of services are the formal and informal agreements. During the past year, in order to provide a close working guide as well as clarification of responsibilities in the post partum period, a formal affiliation agreement was developed. Procedural components of the programs are outlined under the agreement. Contract agreements for nurse practitioner services are outlined in the form of a legal contract. Included in the time allotment in the the obstetrical contract is the attendance at the Health Department's monthly Obstetrical Care Committee. The purpose of this group is assessment of program needs so that recommendations and changes for improvements may be made. Through her attendance, linkage between agencies may occur so

that each interest is represented. The contract also provides training time on issues of reproductive health.

A strength of the integration further becomes apparent when referrals are made for treatment of sexually transmitted diseases. Historically, referrals were given to the patient in an unsystematic manner. Patients were explained their problem and offered referral to the local clinic. Through the development of a formal affiliation agreement, standardized referral forms are utilized. Through the agreement, clearer documentation and clinical tracking result in improved service delivery. An additional benefit derived from the nurse practitioner contract in the obstetrical clinic is the confidence level of the STD clinic physician and staff in the diagnosis of suspected infections. Through exposure to the knowledge and practices of the nurse practitioner, care and treatment has been expediated. Additionally, the total cumulative effect of both staffs interacting on a regular basis has improved communication on all levels.

Another affiliation agreement has been developed for the provision of nutrition services and counseling from the Health Department's registered dietician. The agreement provides the mechanism for Family

Planning agencies to assure compliance with state ambulatory care regulations and federal funding requirements. Utilizing the triplicate referral form, nutrition treatment goals and plans may be accomplished jointly. Similar concepts are implemented when referrals to other programs are initiated for Family Planning clients to child health, special child health and W.I.C. services. Patient counseling, referral, and service availability are discussed with telephone number and contact name provided. A development for the future is the utilization of the physical examination conducted by Women's Health for women subsequently seeking contraception. Patient inconvenience would be decreased, and costs reduced through use of recent exam and laboratory testing.

An integral component of the program is staff attitude and commitment to the concepts of integration. Administration may assign staff with specific directions, however unless the concepts and goals are clearly understood, informal "road blocks" may be initiated. The integration of two agencies could pose serious questions and concerns unless strong relationships are established between agency supervisors

and program directors. Ideological, personality and professional conflicts may arise if mechanisms are not build in for problem resolution. The absence of the supervisor or the regularly assigned family planning staff could cause further disruption in patient care, flow and implementation of the concept. Therefore, an essential element for all staff is initial and ongoing orientation to the model.

In the recruitment of nurse practitioners to the Family Planning Agency, the obstetrical service appears to provide a strong incentive. In interviews, nurse practitioners indicated high interest to have diversification of duties and utilization of a second complete set of skills. Historically, Family Planning programs draw only on the gynecological skills of the clinician resulting in frustration. It is anticipated that through the use of these skills, the "classic burn out" may be diverted. Through the nurse practitioner training program, student nurse practitioners are placed for clinical rotation and have indicated this rotation to be one the most effective and valuable to them.

A byproduct of the system has been increased staff utilization of

each other as resource people. Educational materials, participation in in-house and other training has been shared more often. The closeness of staff has facilitated sharing of workshop availability training and increased communication on the staff level.

For the broader community, the appearance of an integrated coordinated care system abates stereotypical concepts of government funded/sponsored program, i.e., less than professional, apathetic, and non-caring. Community feedback indicates that coordinated efforts are seen as cost effective, and meeting general community expectations and needs. While the initial work of coordination is long and time involved, the cumulative result is impressive. Community leadership has also resulted through the integration of the two systems in the development of a network to address Adolescent Pregnancy, Healthy Mothers and Babies Coalition and other health issues. With the framework as a nucleus, a series of community education opportunities have developed. Programs cover a wide variety of topics and enjoy the opportunity to have other health care and educational institutions as collaborative partners for broad based programming.

The model is easy to adopt, however it requires intensive and

ongoing commitment. Within our program, the banner has been healthy families, mothers, and healthy babies. But even greater than this, the goal is to offer a coordinated, comprehensive care system to alleviate traditional fragmented delivery models. To the best of the Health Department and Family Planning abilities, we have tried to provide the market place concept, all services, here, choose what you want and need.